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Mikkel C. Jarman, DPM

DATE: ____/____/____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE/ZIP: _____

PREFERRED PHONE NUMBER: _____ MAY WE LEAVE A MESSAGE? : YES NO

ALTERNATE PHONE NUMBER: _____ MAY WE LEAVE A MESSAGE? : YES NO

EMAIL ADDRESS: _____ TEXT REMINDERS : YES NO

PRIMARY LANGUAGE: _____ HOW DID YOU HEAR ABOUT US? _____

PARENT INFORMATION

PLEASE CIRCLE ONE:

MOTHER STEP-MOTHER LEGAL GUARDIAN

NAME: _____

CELL#: _____

WORK#: _____

DATE OF BIRTH: ____/____/____

EMPLOYER: _____

EMERGENCY CONTACT INFO:

NAME/PHONE#: _____ RELATIONSHIP: _____

NAME/PHONE#: _____ RELATIONSHIP: _____

PLEASE CIRCLE ONE:

FATHER STEP-FATHER LEGAL GUARDIAN

NAME: _____

CELL#: _____

WORK#: _____

DATE OF BIRTH: ____/____/____

EMPLOYER: _____

PEDIATRICIAN: _____ OFFICE: _____ PHONE: _____

PHARMACY: _____ CROSS STREETS: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

MEMBER ID#: _____ GROUP#: _____

POLICY HOLDER NAME: _____ DOB: ____/____/____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

MEMBER ID#: _____ GROUP#: _____

POLICY HOLDER NAME: _____ DOB: ____/____/____

RELATIONSHIP TO PATIENT: _____

PATIENT NAME: _____

DOB: ____/____/____

MEDICAL HISTORY

PLEASE LIST ALL KNOWN ALLERGIES:

_____	_____
_____	_____
_____	_____
_____	_____

CURRENT DAILY/SEASONAL MEDICATIONS AND DOSAGE:

_____	_____
_____	_____
_____	_____
_____	_____

PATIENT HEIGHT: _____ PATIENT WEIGHT: _____ PATIENT SHOE SIZE: _____

WHAT AGE DID YOUR CHILD:

CRAWL: _____ | STAND: _____ | WALK: _____

MEDICAL CONDITIONS/ILLNESSES

<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> AUTISM	<input type="checkbox"/> BONE / JOINT PAIN	<input type="checkbox"/> BLEEDING
<input type="checkbox"/> CEREBRAL PALSY	<input type="checkbox"/> CONGENITAL HEART DISEASE	<input type="checkbox"/> CYSTIC FIBROSIS
<input type="checkbox"/> DIABETES	<input type="checkbox"/> DOWN SYNDROME	<input type="checkbox"/> HEART MUMUR
<input type="checkbox"/> HIP DYSPLASIA	<input type="checkbox"/> INFECTION BONE / JOINT	<input type="checkbox"/> LIGAMENT LAXITY
<input type="checkbox"/> SEIZURES/EPILEPSY	<input type="checkbox"/> SPINA BIFADA	<input type="checkbox"/> SPRAIN/DISLOCATION
<input type="checkbox"/> OTHER _____		

REASON FOR VISIT: _____

WHEN DID PROBLEM FIRST START? _____ DURATION OF PROBLEM: _____

LIST ANY PRIOR TREATMENTS FOR THIS PROBLEM: _____

IF APPLICABLE, HOW DOES YOUR CHILD DESCRIBE THEIR PAIN? PLEASE CIRCLE:

SHARP / DULL / ACHING / BURNING / RADIATING / ITCHING / STABBING

OTHER: _____

PATIENTS NAME: _____

DOB: ____/____/____

PLEASE CIRCLE ONE:

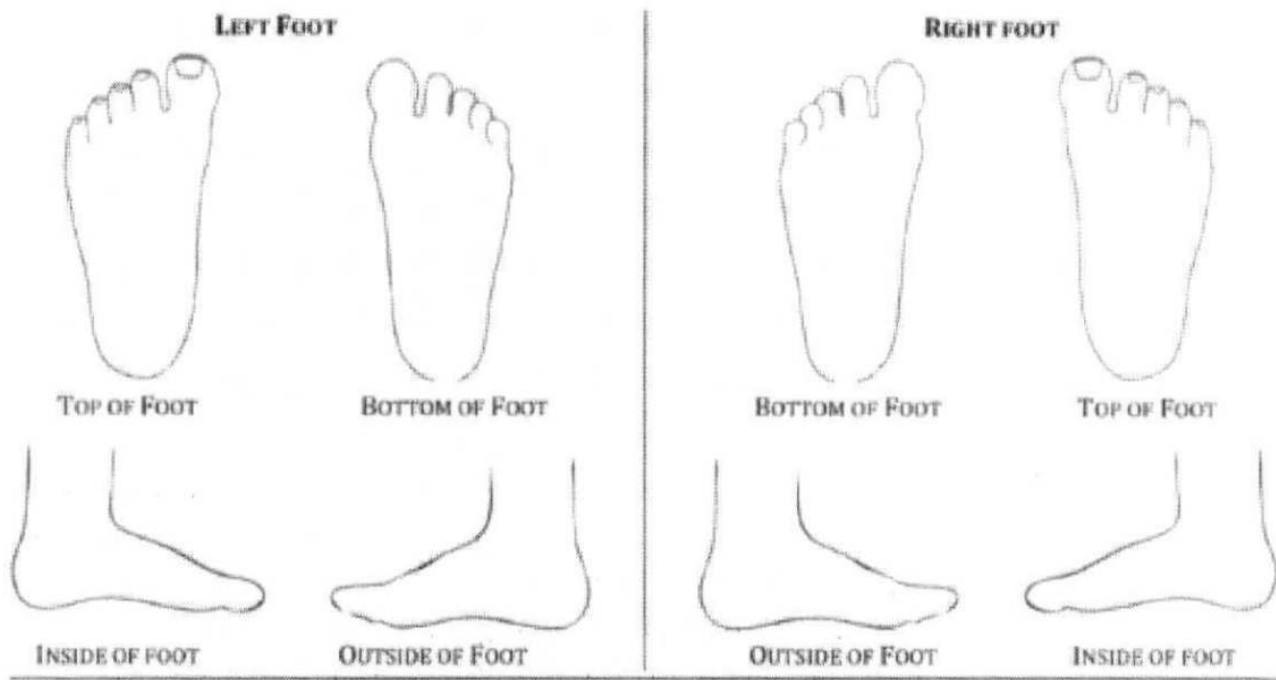
PROBLEM CAUSED BY INJURY? **YES / NO**

DOES PROBLEM AFFECT ABILITY TO PARTICIPATE IN SPORTS/ACTIVITIES? **YES / NO**

WHAT MAKES PAIN FEEL WORSE? **STANDING / WALKING / RUNNING**

SINCE THE PROBLEM STARTED HAS PAIN: **STAYED THE SAME / BECAME WORSE / IMPROVED**

USING THE DIAGRAM BELOW, CIRCLE WHERE PAIN/PROBLEM IS LOCATED:



TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTION ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY CHILD'S HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS OR HISTORY.

Printed name of Parent/ Legal Guardian

Signature of Parent/ Legal Guardian

Date

FINANCIAL POLICY

Thank you for choosing Preferred Foot and Ankle Specialists/Pediatric Foot and Ankle as your preferred foot care provider. We are committed to provide you the best care possible. Your clear understanding of the financial policy agreement is important. Please read carefully and initial and sign where indicated. A copy will be provided for you upon request.

Insurance: As a courtesy we, Preferred Foot & Ankle Specialists/Pediatric Foot and Ankle will verify your benefits. Your insurance policy is a contract between you and details of your insurance including co-pays, deductibles, coinsurance and non-covered services. Coverage, benefits, and quotes given are not a guarantee of payment or coverage and can change. If your insurance company does not pay the practice within 60 days, the balance owed will automatically be billed to you.

Initial: _____

Proof of Insurance: We will bill your insurance with the information you provide us. Your failure to provide us with the accurate information could result in claim denial. If this occurs you assume responsibility for the entire amount of the claim. If we later receive payment from your insurance, we will refund any overpayment. If required, obtaining the proper referral from your primary care physician is your responsibility. Failure to have a valid referral the patient will be responsible to pay in full or reschedule appointment.

Initial: _____

Co-pays & Deductibles: All copays, deductibles and coinsurance are due at time of service. We do not bill for co-pays. This arrangement is part of your contract with your insurance company. Failure to collect dues at time of service can be considered as fraud. **Initial:** _____

DME: If any DME(cam boot/night splint/ankle brace) is prescribed/dispensed at time of service, we collect our adjusted fee per your insurance. If any overpayment is made, you will be issued a refund once claim has processed with your insurance company. **Initial:** _____

Payment: Payment is expected at the time of your visit. Our office accepts cash, check, credit and care credit. Payment will include any unmet deductible, coinsurance, copayment and non-covered charges from your insurance company. After 90 days of non-payment accounts may be subject to our collections process. **Initial:** _____

If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our billing department.

Non-covered services: Please be aware that some or all the services you receive may be non-covered or not considered medically necessary by your insurance company. Any service determined not covered by your plan will be your responsibility. **Initial:** _____

Pediatric Patients: The accompanying parent or adult is responsible for any payment for copays, deductibles, or coinsurance amounts at the time of appointment. **Initial:**_____

Missed Appointments: We appreciate a 24-hour advance notice in any appointment cancellation or reschedule. Failure to notify will result in a \$25 no-show fee. Multiple no show or cancellations could result in a \$75 fee.
Initial:_____

Forms/Documents: Any FMLA/disability paperwork, and/or extra forms that are to be completed by the providers will result in a \$25 completion fee. This excludes any work notes/school notes.
Initial: _____

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY PREFERRED FOOT AND ANKLE SPECIALIST/PEDIATRIC FOOT AND ANKLE. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTIONS IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.

Printed name of patient or responsible party

Date

Signature of patient or responsible party

ACKNOWLEDGMENT OF PRIVACY PRACTICES

THE PRIVACY OF YOUR MEDICAL RECORDS AND PERSONAL INFORMATION IS IMPORTANT TO US. DOCUMENTATION OF YOUR INFORMATION AND MEDICAL TREATMENT/ SERVICES RENDERED ARE CREATED TO PROVIDE YOU WITH QUALITY CARE AND COMPLY WITH HIPAA GUIDELINES. PREFERRED FOOT AND ANKLE SPECIALISTS/ PEDIATRIC FOOT AND ANKLE MAY DISCLOSE INFORMATION FOR TREATMENT, OR TO HEALTHCARE PERSONNEL FOR THE PURPOSE OF CARE AND TO OBTAIN ANY AUTHORIZATION/PRE-CERTIFICATIONS.

I ACKNOWLEDGE THAT A FULL COPY OF PREFERRED FOOT AND ANKLE/PEDIATRIC FOOT AND ANKLES PRIVACY PRACTICES IS AVAILABTE ON THEIR RESPECTED WEBSITES/OFFICE CAN PROVIDE A HARD COPY AT MY REQUEST.

PATIENT NAME (please print)

Date

Parent/Guardian/Legal Representative

Signature

ANY INFORMATION YOU DO NOT WISH TO DISCLOSE MUST BE SPECIFIED IN WRITING. ANY INFORMATION BEING REQUESTED TO BE RELEASED TO ANYONE BESIDES A REFERRING/TREATING PHYSICIAN MUST BE SUBMITTED TO US IN WRITING

PLEASE LIST THE NAMES OF THOSE THAT YOU GIVE OUR OFFICE PERMISSION TO SPEAK WITH OR OBTAIN COPIES OF YOUR MEDICAL RECORD/MEDICAL CONDITION.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Signature of Patient/Guardian

Consent for Treatment of Minor

Patient's Name: _____

Date of Birth: ____/____/____

I, the undersigned, parent/guardian of _____, a minor, do hereby authorize and direct Pediatric Foot & Ankle to provide care.

Initials: _____

Consent for Parents or Guardians for Authorized Persons

As the biological parent or stepparent/guardian of _____, I am granting permission for the below listed person(s) to bring my child in for treatment and or care

PLEASE SELECT ONE OF THE FOLLOWING CHOICES:

_____ **Initial** – I am granting full permission, meaning the below-listed person(s) will be allowed to agree to treatments, and know all health history pertaining to my child.

_____ **Initial** – I am granting permission, meaning the below-listed person(s) is only allowed to bring in, and will have access to all health history, but not allowed to agree to treatment without my direct consent.

_____ **Initial** – I am granting limited permission, meaning the below-listed person(s) is allowed to bring my child into the office, but is not allowed access to any medical information or treatment of my child. I will be informed of the visit results, and I will be notified prior to any treatment for my child.

Please list person(s) here

Consent to leave voicemail

I am granting to Pediatric Foot & Ankle to leave phone messages regarding my child's medical health to the number(s) provided on the registration form. This consent will remain in effect until rescinded in writing.

Parent/Guardian Signature

Date